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ABSTRACT

The health needs of the approximately three million migrant and seasonal farmworkers and their families are clearly among the greatest needs of any population group in the country. In 1962 the Migrant Health Act became the first legislation intended to address some of the health needs of migrants. By 1976 Migrant Health Centers had served 415,000 migrant and seasonal farmworkers and had provided primary health services, supplemental health services, referrals, hospitalization, and payment for these services. The centers also provide environmental health services. The program annually supports 92 projects, 35 of which are the health centers. Almost all of the high migrant impact areas have been penetrated by the program. Some obstacles hinder program effectiveness. Most states view the problem of migrants as a federal problem and assume little or no responsibility for migrant health care. Many health services are located far from migrant camps and transportation is a problem. Migrant health project teams may be prevented from entering a camp without the permission of the grower. Inadequate funding is the greatest problem of all. In 1976 it was estimated that providing a minimal level of primary care would require $61 million; $30 million was appropriated for the program. Recommendations to upgrade and expand health facilities and programs for migrant workers conclude this report. (DS)

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FEDERAL RESOURCES & RURAL HEALTH

MIGRANT HEALTH PROGRAM

(RURAL HEALTH REPORT #7)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Migrant Health Program

Migrant Workers and Their Health

There are approximately three million migrant and seasonal farmworkers and their dependents in the United States. While farm laborers can be found throughout the country, they are concentrated in ten states: Texas, California, Florida, Michigan, Arizona, Oregon, Ohio, Washington, New Mexico, and New York. During the winter months, the majority of migrant workers return to so-called home-base areas in Texas, California, Florida and Arizona.

The health needs of migrant and seasonal farmworkers and their families are clearly among the greatest of any population group in the country. Existing health financing programs such as Medicare and Medicaid, Workman's Compensation, and employer sponsored health insurance plans have not been responsive to the special needs of migrants. In many instances, stringent eligibility requirements have greatly reduced the number of people covered by these programs. In addition, the administration of these programs is not structured to serve migrants as they move and work during the course of a season.

Migrant Health Legislation

The Migrant Health Act of 1962 was the first legislation intended to address some of the health needs of migrants. This legislation was prompted by the public's concern over the communicable nature of many diseases prevalent among farmworkers. Migrant health was perceived as a public health program.

In fiscal year 1963, $750,000 went into the Migrant Health Program. Almost 80 percent of the grants available through this program went to public health departments, which were made responsible for treating migrants in their area. However, many of these agencies were not adequately equipped and staffed to provide a broad range of services to farmworkers and their families. It became evident that this method of dealing with migrant health problems was unsatisfactory.[1/]

The Migrant Health Act was amended in 1965 and then again in 1970. In 1970 the first funds were made available to develop autonomous Migrant Health Centers. The Migrant Health Act was completely rewritten in Title IV of the Special Health Revenue Sharing Act of 1975, (PL 94-63). This legislation authorizes the Secretary of Health, Education and Welfare to make grants to public and nonprofit private entities to develop and operate Migrant Health Centers in high impact areas. High impact areas are defined

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1/ Interview with Office of Migrant Health staff member, Washington, D. C., February 2, 1977.

as those areas where not less than 6,000 migratory and seasonal agricultural workers and their families reside for more than two months in any calendar year. In low impact areas, Public Law 94-63 authorizes migrant health projects, which frequently involve contractual arrangements with health care providers and facilities or health care through public health agencies.

Migrant Health Centers provide comprehensive health services for farmworkers residing in the designated service area. Of an estimated 3 million migrants and seasonal farmworkers and family members, approximately 415,000 were served by Migrant Health Centers and projects in FY 1976.[2/] Grant funds to Migrant Health Centers are used to provide primary health services, supplemental health services, and referrals to providers of supplemental health services, including hospitalization, and payment for these services. Grants to these centers range from $200,000 to $1 million, depending on the location, service area, facilities, etc.

By law, Migrant Health Centers are also required to provide environmental health services for the detection and alleviation of unhealthful conditions associated with housing and related sanitary facilities, with parasitic infestation, field sanitation, and other environmental factors. Additional services provided by the Centers include accident prevention programs, excessive pesticide exposure, and information on the availability and proper use of health services.

2/ Ibid.

Migrant Health Centers are required to establish a governing board, a majority of whose members must be drawn from, and be representative of the individuals served by the Center. The Board establishes general policies for the Center and approves the Center's annual budget and the selection of a director.

Public Law 94-63 also establishes a National Advisory Council on Migrant Health to advise, consult with, and make recommendations to the Secretary of HEW concerning the operation, selection, and funding of Migrant Health Centers and other program matters. The Council consists of 15 members, at least twelve of whom are members of the governing boards of Migrant Health Centers and other entities assisted under the Act. The remaining three members are individuals qualified in the medical sciences or in the administration of health programs.

Program Data

The appropriations level for the Migrant Health Program remained constant between FY 1973 and FY 1975, and increased slightly for FY 1976 and FY 1977. It is projected that the FY 1978 appropriations will be about $30 million. The following table indicates the funding levels in recent years.

FISCAL YEAR	APPROPRIATION
1973	$ 23,750,000
1974	23,750,000
1975	23,750,000
1976	25,000,000
1977	30,000,000
1978	30,000,000 (projection)

Source: U. S. Department of Health, Education and Welfare, Bureau of Community Health Services, "Migrant Health Centers," (Xeroxed chart).

The Migrant Health Program annually supports a total of 92 projects, 35 of which are Migrant Health Centers. A little over sixty percent of the Migrant Health Program annual budget goes to support these Centers.[3/]

The Migrant Health Program has penetrated almost all of the high migrant impact areas. Migrant areas unserved at the present time are predominately low impact areas. Of the 837 low impact counties, only 219 are served by migrant projects, leaving 618 counties unserved.[4/]

3/ Ibid.

4/ U. S. Department of Health, Education and Welfare, Public Health Service, Office of Migrant Health, "Rational for Developing Interstate Entitlement Projects," 1977. (Xeroxed) Page 1.

Some migrant health funds have gone into the Rural Health Initiative Program for the creation of RHI projects in high and in low impact areas. RHI projects now serve approximately 20 areas where migrants work and live. It is estimated that in FY 1977, $5 million of the $30 million available migrant health funds will be used by HEW to provide services to migrants and seasonal farmworkers through RHI projects.[5/]

Hospitalization

The first authorization for hospital care came in FY 1965. From 1965-70, migrant health projects negotiated individual agreements with local hospitals, using grant funds to cover inpatient care. But because of the escalating costs of hospital care and an increased emphasis on ambulatory care, the hospital program was greatly reduced in 1970 in favor of support to ambulatory care programs. Less than $1 million went into hospital care that year, and local communities were expected to assume the majority of hospital expenses for migrants. Unfortunately, local communities did not accept this responsibility.[6/]

5/ U. S. Congress. Senate. Report by Senate Appropriations Committee to accompany H. R. 14232, Department of Labor and HEW and Related Agencies Appropriations Bill, 1977, 94th Congress, 2nd Session, 1976, Report No. 94-997, Page 33.

6/ Interview with Office of Migrant Health staff member, Washington, D.C., December 28, 1976.

The Bureau of Community Health Services (BCHS), concerned with the unmet hospitalization needs of migrants, began to re-examine the problem in 1973. To extend hospital care to more migrant workers, BCHS, with the cooperation and assistance of the Social Security Administration's Bureau of Health Insurance, initiated the Migrant Hospitalization Program (MHP) in January of 1974. The MHP is designed to provide inpatient hospital services, including inpatient medical services, for migrant agricultural workers and their dependents through Migrant Health Projects.

In its first six months of MHP operation, 6 projects and 9 hospitals participated, and 569 patients were admitted for inpatient services. In the following 12-month period, this increased to 12 projects and 19 hospitals, serving 3,400 patients. In 1976, the hospitalization program served 3,125 patients. A total of $5,568,000 was paid out for inpatient care during this 2 1/2 year period.[7/] On July 1, 1976, a limited admissions policy was initiated. Under this policy, the number of patients each project admits annually has been steadily declining.[8/]

Commentary

The Migrant Health Program has made an important start with the limited resources available to it in providing needed services to migrant workers. Unfortunately, a number of obstacles hinder the effectiveness of the program and impede the development of improved health services to migrants.

7/ U. S. Department of Health, Education and Welfare. Public Health Service, Office of Migrant Health, "Migrant Hospitalization Program," 1977. (Xeroxed), Page 2.

8/ Ibid.

Most states view the problem of migrants as a Federal problem and assume little or no responsibility for migrant health care. Local health departments frequently do not cooperate with Migrant Health Centers in providing services to migrants.

The Migrant Health Program is at a disadvantage because the health components of other Federal programs serving migrants are not integrated with the BCHS Migrant Health Program. For example, the Migrant Education Program has a health component which includes physical examinations for children. Children are given these examinations in the schools, but frequently are not referred to Migrant Health Centersor other projects where they can receive the necessary follow-up treatment. The Migrant Health Program staff is currently involved in an effort to integrate the efforts and resources of these two migrant programs. 9/

Migrant Health Projects

According to most observers, projects in low impact areas have had only limited success in serving migrants. Projects in these areas often involve contractual arrangements through local health departments which, in many cases, have not made an adequate effort to inform migrants of available services or to schedule these services at times that are convenient to migrant farmworkers.

9/ Interview with Office of Migrant Health staff member, Washington, D.C., February 24, 1977.

Transportation has been another serious problem in both low and high impact areas. Many health services available to migrants are located long distances from migrant camps. In addition, migrant health project teams may be prevented from entering migrant camps without the permission of the growers.

Funding Levels

The single most significant barrier to improved health care for migrants has been the inadequate funding for the Migrant Health Program. From FY 1973 through FY 1975, there was no increase in funding levels. In 1975, it was estimated that funding for migrant health activities provided less than $25 annually to care for each member of a migrant or seasonal farmworker family, while the average per capita expenditure nationwide was almost $400.[10/] For FY 1977, despite opposition from the Ford Administration, funding was increased modestly from $25 to $30 million.

In 1976 it was estimated that providing a minimal level of primary care to the migrant population would require a total of $61 million. This is about $30 million above the present level, and these figures do not include the cost of needed inpatient hospital care.[11/]

10/ Daniel R. Hawkins, Director, Su Clinica Familiar, Summary of Prepared Statement Submitted to the U. S. House of Representatives Subcommittee on Labor, Health, Education and Welfare, November 1975, (Xeroxed), Page 4.

11/ Idem, Summary of Prepared Statement Subcommittee to the U. S. House of Representatives Subcommittee on Labor, Health, Education and Welfare, March 1976, (Xeroxed), Page 3.

Migrant Health Centers, along with most health care facilities, have faced tremendous increases in operating expenses. Increases in the costs of administration and supplies has been considerable, and malpractice premiums and specialty referral charges have spiraled, with rates in some categories exceeding 100 percent.[12/] Informed observers note that increased costs of health care may force some Migrant Health Centers to cut back on the health services they provide.

Migrant Hospitalization Program

Since migrants are frequently medically indigent, they have a particularly difficult time getting admitted to hospitals. It is not uncommon for migrants to be refused admission to hospitals because they do not have health insurance or adequate personal funds. In many instances, these hospitals were constructed or renovated with Hill-Burton Act funds and as such are required by law to provide free or low-cost services to the medically indigent. However, too often hospital administrators themselves are unaware of their responsibilities and fail to provide needed services to migrant families.

The fundamental problem is that the MHP has not been funded at adequate levels to meet the hospitalization needs of farmworkers and their dependents. As has been discussed, a limited admissions

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12/ Idem, Summary of Prepared Statement, November 1975, Page 4.

policy was instituted when the program reached its maximum service level in July of 1976. This policy excludes even a greater number of needy individuals.

Recommendations

In view of the serious continuing health problems facing farmworkers and their families, the following recommendations are offered:

- Mechanisms should be developed to encourage state and local health departments to recognize their responsibility to serve migrants residing temporarily in the area, irrespective of the existence of local migrant health projects, and to cooperate with these projects in serving migrants.

- The Migrant Health Program staff should expand its liaison efforts to integrate the various programs which serve migrants, in order to maximize resources, to facilitate referrals, and to aid in the dissemination of information concerning the availability of services.

- Migrant Health Projects in low impact areas should increase their efforts to provide information to migrants on the availability of health services.

- Migrant Health Projects in low impact areas should schedule health services in accordance with the migrant work schedule, preferrably making services available near or at the camps, and should provide transportation to the services when necessary.

- Migrant Health Program funds should be used only in health centers and projects that are especially designed to meet the unique needs of migrant and seasonal farmworkers; these funds should not be used in the Rural Health Initiative program.

- The National Advisory Council on Migrant Health should be encouraged to play a more active role in the development and implementation of Migrant Health Program policies.

- Funding levels for the Migrant Health Program should be substantially increased to enable Migrant Health Centers to provide the maximum service capacity, to develop new projects to reach unserved migrant and seasonal farmworkers, and to permit expansion of the Migrant Hospitalization Program into a major hospitalization program for migrants.

The harsh winter of 1976-77 has destroyed crops across the country, which will leave many migrants jobless this year and less able than ever to afford proper health care. This makes it even more important to upgrade and expand health facilities and programs available to migrant workers. Immediate implementation of the recommendations set forth above is urgently needed.

BIBLIOGRAPHY

Hawkins, Daniel R. Director. Su Clinica Familiar. Summary of Prepared Statement Submitted to the U. S. House of Representatives Subcommittee on Labor, Health, Education and Welfare, November, 1975. (Xeroxed).

Hawkins, Daniel R. Director. Su Clinica Familiar. Summary of Prepared Statement Submitted to the U. S. House of Representatives Subcommittee on Labor, Health, Education and Welfare, March, 1976. (Xeroxed).

U. S. Congress. House. Report by the Committee on Interstate and Foreign Commerce Together with Separate, Additional and Minority Views to accompany H. R. 4925. Health Revenue Sharing and Health Services Act of 1975. 94th Congress, 1st Session, 1975.

U. S. Congress. Public Law 94-63. Health Revenue Sharing, July 29, 1975. 94th Congress, 1st Session, 1975.

U. S. Department of Health, Education and Welfare. Public Health Service. "National Advisory Council on Migrant Health." (Xeroxed).

U. S. Department of Health, Education and Welfare. Public Health Service. Health Services Administration. Program Analysis. (Xeroxed).

U. S. Department of Health, Education and Welfare. Division of Monitoring and Analysis. Bureau of Community Health Services. "Migrant Hospital Program: Statistical Summary."1976. (Xeroxed).

U. S. Department of Health, Education and Welfare. Bureau of Community Health Services."Migrant Health Centers."1976. (Xeroxed)

U. S. Department of Health, Education and Welfare. Public Health Service. Office of Migrant Health. "Migrant Hospitalization Program." 1977. (Xeroxed).

U. S. Department of Health, Education and Welfare. Public Health Service. Office of Migrant Health. "Environmental Health Services." 1977. (Xeroxed).

U. S. Department of Health, Education and Welfare. Public Health Service. Office of Migrant Health."Summary Comparison - Performance Data, Estimated Total FY 1977."1977. (Xeroxed).

U. S. Department of Health, Education and Welfare. Public Health Service. Bureau of Community Health Services. The Migrant Health Program. DHEW Publication No. HSA 76-6604.

U. S. Department of Health, Education and Welfare. Public Health Service. Programs of the Bureau of Community Health Services. 1973. DHEW Publication No. HSA 74-5007.

U. S. Department of Health, Education and Welfare. Public Health Service. "Grants for Migrant Health Services, Interim Regulations, Part III." Federal Register 41 (September 13, 1976) 178.

U. S. Department of Health, Education and Welfare. Public Health Service. Promoting Community Health. 1975. DHEW Publication No. HSA 75-5016.

U. S. Department of Health, Education and Welfare. Public Health Service. Office of Migrant Health."BCHS Common Reporting Requirements." 1977. (Xeroxed).

U. S. Department of Health, Education and Welfare. Public Health Service. Office of Migrant Health. "Rational for Developing Interstate Entitlement Projects." 1977. (Xeroxed).